REPUBLICA	PRINTED: 09/10/2007 FORM APPROVED OMB NO. 0938-0391
(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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STREET ADDRESS, CITY, STATE, ZIP COL 1600 FRANKLIN STREET, NE	DE

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

(X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES IDENTIFICATION NUMBER: A BUILDING IND PLAN OF CORRECTION B. WING _ 09G161 STREET NAME OF PROVIDER OR SUPPLIER 1600 WASHINGTON, DC 20017 WHOLISTIC 08 PREVIDER'S PLAN OF CORRECTION (X6) SUMMARY STATEMENT OF DEFICIENCIES ID (EACH CORRECTIVE ACTION SHOULD BE CROSS-LEFERENCED TO THE APPROPRIATE (X4) ID KEACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX DATE PRÉFIX REGULATORY OR LEC IDENTIFYING INFORMATION) DAT DEFICIENCY) TAG W 000 INITIAL COMMENTS W 000 A recertification survey was conducted from August 20, 2007 through August 22, 2007. The survey was initiated using the fundamental survey process. A random sample of two clients were selected from a population of four females with various disabilities. The findings of this survey were based on observations at the group home, one day program, interviews at both the group home and day program, review of clinical and administrative records to include the facility's unusual incident and investigation reports. 483.420(a)(2) PROTECTION OF CLIENTS W 124 W 124 RIGHTS The facility must ensure the rights of all clients. The facility will ensure the rights Therefore the facility must inform each client, of all individuals. Parents and/or parent (if the client is a minor), or legal guardian, legal guardians will be informed of the client's medical condition, developmental of the individuals medical 124-A07d and behavioral status, attendant risks of conditions, developmental and treatment, and of the right to refuse treatment. behavioral status, attendant risk of treatment and the right to refuse treatment. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility falled to ensure the right of each client or their legal guardian to be informed of the client's medical condition, developmental and behavioral status, attendant risks of treatment, and the right to refuse treatment for two of two clients included in the sample. (Client #1 and #2) The findings include: 1 a. During the medication pass on 8/20/07 at

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

President

TITLE

(Kd) DATE 9/20/07

the hours Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients, (See instructions.) Except for number homes, the findings stated above are disclosable 90 days following the date of survey whether of not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

PRINTED: 09/10/2007

DEPART	MENT OF HEALTH	AND HUMAN SERVICES & MEDICAID SERVICES				OMB NO.	APPROVED 0838-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MI	ILTIPLE CONSTRUCTION DING	· · · · · · · · · · · · · · · · · · ·	(X3) DATE SU COMPLE	IRVEY TED
		09G151	B. WIN	<u> </u>		08/2	2/2007
NAME OF P	ROVIDER OR SUPPLIER TIG 08			STREET ADDRESS, CITY 1600 FRANKLIN STR WASHINGTON, DO	REET, NE C 20017		· · · · · · · · · · · · · · · · · · ·
(X4) ID PREFIX TAG	/EACH DESIGIONO!	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	(EACH CORE	R'S PLAN OF CORRE RECTIVE ACTION SH RENCED TO THE AP DEFICIENCY)	HOULD B定	(XS) COMPLETION DATE
W 124	6:17 PM, Client #1 rng, and Tegratol 2 the Trained Medica day at approximate medication was pro behaviors. Review orders dated 7/30/ 3:39 PM revealed incorporated in a E dated 8/1/07, to ac with physical aggre noncompliance, is grinning inappropri her hands, and stic	was administered Ability 15 to mg 2 tabs. Interview with ation Nurse (TME) on the same aly 6:20 PM revealed that the escribed for maladaptive of the client's physicians 07 on 8/21/07 at approximately that Ability and Tegretol was sehavior Support Plan (BSP) idress behaviors associated ession, self-injurious behaviors, liking to herself, laughing or lately, covering her face with eking her hands into her pants.	W	Client #2's to be the h her daughte	mother has lealth care r. The doc and should b	agent for uments hav	9/22
	Professional (QMF approximately 1:30 mother was very in consents for treature December 2007 P 8/21/07 at approximate did not evident	RP) on 8/22/07 at 55 PM revealed that Client #2's 55 PM revealed that Client #2's 56 PM revealed in her life and gives ment. Review of Client #1's sychological Assessment on mately 2:50 PM revealed that lice the capacity to make slone or provided meaningful					

FORM CMS-2567(02-99) Previous Versions Obsolete

or entity.

Input into decisions or provided meaning of input into decisions regarding her habilitation planning, placement, treatment, financial, or medical matters. The Client could not execute a durable power of attorney. There was no documented evidence that the facility informed

the use of his psychetropic medications and corresponding BSP. Additionally, the facility falled to provide evidence that substituted consent had

been obtained from a legally recognized individual

b. Review of the Client #1's current (7/30/07)

Cilent #1's mother or a legally-authorized representative, as appropriate, of the health benefits and risks of treatment associated with

Event ID: 2ME511

Facility ID: 08G151

If continuation sheet Page 2 of 13

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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CENTERS FOR MEDICARE	A MEDICAID SERVICES		<u>OMB NO. 0938-039</u>
CENTERS FOR MEDICARE STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A BUILDING	(X3) DATE SURVEY COMPLETED
	09 G 151	9. WNG	08/22/2007
NAME OF PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 1600 FRANKLIN STREET, NE	

WHOLISTIC DA

WASHINGTON, DC 20017

WHOLISTIC 08			WASHINGTON, DC 20017				
(X4) ID PREFIX TAG	Summary Statement of Deficiencies (Each Deficiency Must be preceded by full regulatory or LSC Identifying Information)	ID PREFIX TAG	PRIMIDER'S PLAN OF CORRECTION (EAC) CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(%5) COMPLETION DATE			
W 124	Continued From page 2 physician's order sheet on 8/21/07 at approximately 11:39 AM revealed an order on 2/5/07 for deep conscious sedation for Gyn appointment. Further record review falled to evidence that consent had been obtained prior to the administration of the medication. Interview with the Qualified Mental Retardation Professional (QMRP) 8/21/07 revealed that Client #1's mother signs all consents for medications and medical procedures. Further interview with the QMRP revealed that Human Rights Committee (HRC) had approved the use of the sedative medications prior to the implementation. c. On 12/8/06, Client #1's medication of ability was discontinued at its currently prescribed dosage and increased to ability 15 mg Q AM and PM. Interview with the Qualified Mental Retardation Professional (QMRP) 8/21/07 revealed that Client #1's mother signs all consents for medications and medical procedures. The facility failed to provide avidence that substituted consent had been obtained from a legally recognized individual or entity.	W 124					
	2 a. During the medication pass on 8/20/07 at 6:06 PM, Client #2 was administered Lorazapam 0.5 mg, Seroqual 200 mg 2 tabs, Zyprexa 10 mg, and Heldel 6 mg. Interview with the TME on the same day revealed that the medication was prescribed for meladaptive behaviors. Interview with the Qualified Mental Retardation Professional (QMRP) on 8/21/07 at approximately 2:00 PM revealed that Client #2 had an involved sister, but had not been able to establish contact in over a year with the sister. Review of Client #2's August 2007 Psychological Assessment on 8/21/07 at approximately 1:50 PM revealed that						

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

TATEMENT	TOF DEFICIENCIES OF CORRECTION (X1) PROVIDER/SUPPLIER/GLIA IDENTIFICATION NUMBER;		1	IULTIPI	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		. 09G151	B. Wi				2/2007	
NAME OF PI	ROYIDER OR SUPPLIER			100	SET ADDRES), CITY, STATE, ZIP CD 00 FRANKLIN STREET, NE ASHINGT(IN, DC 20017	DE		
(X4) ID PREFIX TAG		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREI TAG	TX.	PR IVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS REFERENCED TO THE DEFICIENCY)	SKOULD BE	COMPLETION DATE	
W 124	Independent decis meaningful input in habilitation plannir financial, or medic documented evides Cilent #2 or a lega as appropriate, of treatment associal psychotropic medicationally evidence that sub obtained from a legal entity. b. On 12/4/06, a was added to Cilent #2 or a document informed Cilent #2 representative, as benefits and risks the use of his psychotropic evidence.	ce the capacity to make lons on her behalf or provided no decisions regarding hering, placement, treatment, all matters. There was no more that the facility informed ally-authorized representative, the health benefits and risks of the dwith the use of his ications and corresponding, the facility falled to provide attituted consent had been spally recognized individual or make medication of ability 15 mg and #2's medication regimen and ozaril was discontinued. There are evidence that the facility or a legally-authorized appropriate, of the health contropic medications and sp. Additionally, the facility falled on a legally recognized individual or ce that substituted consent had om a legally recognized individual		124				
	was added to Climaddress increasing was no document informed Client frepresentative, a benefits and risk the use of his pacomesponding B	new medication Seroquel 400 mg ant #2's medication regimen to ang symptoms of paranoia. There at the devidence that the facility if or a legally-authorized a appropriate, of the health is of treatment associated with ychotropic medications and SP. Additionally, the facility faile on a legally recognized individual	d			·		

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTER	S FOR MEDICARE	& MEDICAID SERVICES				OND NO.	
TATEMENT	TEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A BUILDING			(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER			10	ret addres); city, state, zip code 600 Franklin Street, ne		
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(X4) ID PREFIX TAG	/프로스티 트립바스(발시스)	NTEMENT OF DEFICIENCIES Y must be preceded by full BC identifying information)	D PREP YAC		PROMOTER'S PLAN OF CORRECTIVE ACTION SHO (EACH CORRECTIVE ACTION SHO CROSS- REPERENCED TO THE APP DEFIGIENCY)	CHON COULD BE ROPRIATE	(XB) COMPLETION DATE
W 124	for Client #2 to obt and was still awalt	has submitted an affivedit form ain guardianship to the doctor ng the doctor's review and	W	124	Doctor has reviewed and guardian package submitt case management.	approved	9/20
W 125	The facility must a Therefore, the faci individual clients to	nsure the rights of all clients, lity must allow and encourage axercise their rights as clients as citizens of the United States, to file complaints, and the right	w	126	The facility will ensure of all persons. All perbe encouraged to exercively the second of the and citizens of the U.S. the right to file complethe due process. Client mother is her surrogate maker.	rsons will se their facility . includi sints and t #2's	ng
	Based on interview failed to ensure the capacity to make I received assistant decision-maker for needs, for two of its sample. (Client # The findings incluing facility failed to protected by make				See 124		
W 153	with making decise [See W124] 483,420(d)(2) STACLIENTS The facility must a mistreatment, neg	representance to assist them sions regarding their treatment. AFF TREATMENT OF ensure that all allegations of glect or abuse, as well as an source, are reported	\ \ \	/ 163	3		

PRINTED: 09/10/2007 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A BUILDING B. WING _ 06/22/2007 09G151 STREET ADDRES }, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1600 FRANKLIN STREET, NE WASHINGTON, DC 20017 WHOLISTIC OB (X5) CONFLETION DATE PRINCIPER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES 10 (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (EACH DEPICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC (DENTIFYING INFORMATION) (X4) ID PREFIX PREFIX DAT DAT DEFICIENCY) W 153 Each client has a legally Continued From page 5 W 153 sanctioned representative to Immediately to the administrator or to other assist them withe making decisions officials in accordance with State law through regarding their treatment. established procedures. This STANDARD is not met as evidenced by: Based on interview, review of the investigative and incident reports and the review of the facility's Incident Management System (IMS), the facility falled to ensure that all allegations of mistreatment, neglect or abuse as well as injuries of unknown origin were reported immediately to the administrator or to other officials as required by State Law [22 DCMR Chapter 35 - 3519.10] through established procedures for one of two clients included in the sample. (Client #1) The finding includes: t is not an allegation of Review of the incident reports on 8/21/07 at 10:47 This 🖴 abuse, mistreatment, neglect, or AM revealed that on 1/7/07, Client #1 was injury of unknown orgin. It was an "banging up in her room." The client came down unusual event but does not fall stairs with staff and explained that a voice name

W 159

FORM CMS-2567(02-99) Previous Versions Obsolute

facility's administrator.

483,430(a) QUALIFIED MENTAL

RETARDATION PROFESSIONAL

"Angle" was messing with her. The client picked

up a chair and a place of tile and attempted to hit

ran into the living room area threw backpack and

hit staff in the face. Staff was injuried (face and lip swollen). There was no evidenced that the following incident had been reported to the

Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional.

staff, however other staff Intervened. Client #1

Event (D: 2ME811

Facility ID: 0803151

W 159

not apply.

in one of the foremention

categories. Thus, the requirement

for report to administrator dows

If continuation sheet Page 6 of 13

on-going

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 09/10/2007 FORM APPROVED

CENTERS FOR MEDICARE	* MEDICAID SERVICES		OMB NO. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING	(X3) DATE SURVEY COMPLETED
	09G151	8. WING	08/22/2007
NAME OF PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 1600 FRANKLIN STREET, NE	

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WHOLISTIC OB			WASHINGTON, DC 20017			
(X4) ID PREFIX TAG	Summary Statement of Deficiencies (Each Deficiency must be preceded by Full Regulatory or LSC Identifying Information)	ID PRÉFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHI (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETION		
W 159	Continued From page 6 This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility's Qualified Mantal Retardation Professional (QMRP) falled to integrate, coordinate and monitor its clients active treatment programs.	W 156	QMRP will ensure that experson's active treatmer is integrated, coordinate monitored.	it progrem		
	The findings include:					
	1. The QMRP failed to ensure that informed consent were obtained from family/legal guardians for psychotropic medications, sedation, and the implementation of Behavior Support Plans prior to their implementation. [See W124 and W263]		See 124 and 283			
	The QMRP failed to ensure that clients were provided with opportunities for choice and self-management. [See W 247]		See 247			
	3. The QMRP falled to ensure Client #1 was provided opportunities for continuous active treatment in accordance the Physical Therapist recommendations. [See W249]		See 246			
	4. The QMRP falled to ensure to teach clients to use and make informed choices about the use of their adaptive equipment (glasses). [See W436]		See 435			
W 247	5. The QMRP falled to monitor facility compilance with the established fire drill schedule, to ensure that drills were held at least quarterly on every shift. [See W440] 483.440(c)(6)(vi) INDIVIDUAL PROGRAM PLAN	W 2	See 440			
	The individual program plan must include opportunities for client choice and self-management.					

MENT OF HEALTH AND HUMAN SERVICES

PRINTED: 09/10/2007 FORM APPROVED

CENTERS FOR MEDICARE	S MEDICAID SERVICES	·	OMB_NO. 0938-039
STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
AND PLAN OF CORRECTION	IDEN) (PIGATION NOMBER.	B. WING	
	09G151		08/22/2007
NAME OF PROVIDER OR SUPPLIER		STREET ADDRES), CITY, STATE, ZIP CODE 1600 FRANKL N STREET, NE	Ĺ
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WHOLISTIC 08			WASHINGTON, DC 20017			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LEC IDENTIFYING INFORMATION)	ID PREFIX TAG	PRIVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X3) COMPLETION DATE		
W 247	Continued From page 7 This \$TANDARD is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure clients were provided with opportunities for choice and self-management, for two of the two clients included in the sample. (Client #1 and #2)	W 247	Individuals will be afforded opportunities for choice and/or self management during dinner.	9/22		
	The finding includes: The facility failed to ensure Cilent #1 and #2 were afforded opportunities for choice and /or self-management during dinner. During dinner on 8/20/07 at 5:32 PM, direct care staff was observed preparing the table diner style by placing a bowl of soup, a bowl of mixed vegetables, and pitchers of water and sode on the table. The staff was further observed to measure each client portion on to their plate/bowl. Although the dining table was set for family style dining. Client #1 and #2 did not participate in the service of the food.		Person #2 tends to pick her nose Other persons in the home (one resident) in particular does not like to touch her or her food (even if her hands ar washed). However Person #2 can serve herself last to avoid upsetting others.			
W 249	Interview with the Qualified Mental Retardation Professional (QMRP) on the same day revealed that the clients were "very capable" of assisting direct care staff in serving food. The QMRP further revealed that Client #2 could serve herself independently. 483.440(d)(1) PROGRAM IMPLEMENTATION As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the	W 24!				

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

TATEMENT	EMENT OF DEFICIENCIES PLAN OF CORRECTION (X1) PROVIDER/GUPPLER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A, BUILDING B. WING			(X3) DATE SURVEY COMPLETED 08/22/2007	
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NAME OF P	ROVIDER OR SUPPLIER			16	et addrest, chy. 51412, 2170 00 Franklin Street, ne Ashington, DC 20017	~~ ~ ~	
**UOF19		1	10-		PROMPER'S PLAN OF CO	DRRECTION	(X4) COMPLETION
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W 249	This STANDARD Based on observative review, the facility interdisciplinary temprogram plan (IPP continuous active needed intervention objectives for two (Clients #1 and #2). The findings included intervention objectives for two plants #1 and #2.	Is not met as evidenced by: fion, interview and record failed to ensure as soon as the am formulated the individual), each client received a treatment plan consisting of ons to achieve identified of two clients in the sample.	W		QMRP did follow-up w verification. Staff has been retra Program is now being according to PT reco	ined on goal implemente	9/22
	PM revealed Ciler weights on holding swings and knee exercises). Revia Support Plan (ISF revealed a Physic dated 12/6/06. As recommendation, repetitive activities and down the stee expedition. Furth essessment reveup and down a flight at 100% of the trill interview with the Professional (QM 1:45 PM revealed recommendation that she would for perification. The	staff should encourage a such as vacuuming, going up ps to increase her energy er review of the PT's aled a goal that Client #1 will go ght of stairs 2/2 trials every hour als five (5) times a week. Qualified Mental Retardation iRP) on 8/22/07 at approximately it that she was unaware of the . The QMRP further indicated llow up with the PT for re was no evidence that the goal nented in accordance with the					

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
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NAME OF P	ROVIDER OR BUPPLIER			16	eet addres), city, state, zip code 500 Franklin Street, ne /Ashingt(in, dc 20017		
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W 249	2. [See W247] The to participate in the 483.440(f)(3)(ii) PF	age 9 he facility falled to allow clients air meal time service. ROGRAM MONITORING &	w	249 283	See 247 The committee will ensu	ire that	
	The committee six	ould insure that these programs y with the written informed nt, parents (If the client is a			these programs are condonly with written inforcensent of the individuparents or legal guard	lucted rmed iale	on-going
	Based on interview facility's specially- Rights Committee programs were us	is not met as evidenced by: w and record review, the constituted committee (Human) falled to ensure that restrictive sed only with written consents, nts included in the sample.)			Guardians/health agent obtained for persons #	s are bein 1 and #2.	9/22
-	The findings inclu	des:			·		
	for the use of Clie Support Plan (BS)	an rights committee failed to ned consent had been obtained ant #1's and #2's Behavior P) in conjunction with the use of otropic medications as					
	had been obtained Support Plan (BS) psychotropic med medical appoints Qualified Mental (QMRP) on 8/22	evidence that written consent of for Client #1's Behavior P), for the use of prescribed ilications, and sedation prior to nents. Interview with the Retardation Professional /07 at approximately 1:35 PM ant #2's mother is very involved less consents for treatment. [See	•				

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PTATEMENT	RS FOR MEDICARE OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/BUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M		LE CONSTRU	NOITC	(X3) DATE SURVEY COMPLETED	
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NAME OF P	ROVIDER OR SUPPLIER			10	600 FRANKLI	CITY, STATE, ZIP CODE N STREET, NE N, DC 20017		
(X4) ID PREFIX TAG	SUMMARY 5T	atement of deficiencies Y must be preceded by full LSC identifying information)	ID PREF TAC		/EAGU	IVIDER'S PLAN OF CORREC CORRECTIVE ACTION SHO REFERENCED TO THE APP DEFICIENCY)	OULD BE	COMPLETION DATE
W 436	2. There was no chad been obtained Support Plan (BSI psychotropic medications. Interestation Profes approximately 2:0 not have written in guardian or any or responsible at the QMRP submit guardiantship for the facility must and teach clients choices about the hearing and other devices.	evidence that written consent if for Client #2's Behavior P), for the use of the prescribed leations, and the addition of new relew with Qualified Mental asional (QMRP) on 8/22/07 at 0 PM revealed that Client #2 did aformed consent signed by a ther person identified as there person identified as there of the survey; however, ited paper to obtain the client. [See W124] ACE AND EQUIPMENT furnish, maintain in good repair, to use and to make informed a use of dentures, syeglasses, recommunications aids, braces, a identified by the client.		263	See 124			
	Based on observer review, the facility and make inform adaptive equipm clients included in the finding inclusions du 8/20/07 through observed to weather Qualified Maintenance de la constant de la const	is not met as evidenced by: ation, interview and record y failed to teach clients to use and choices about the use of their ent (glasses) for one of two n the sample. (Client #2) des: ring the survey period from 8/22/07, Client #2 was not ar her glasses in the home or the interview with House Manager and intal Retardation Professional 1/07 at approximately 2:10 PM						not Page 11 of

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DEPARTMENT OF HEALTH CENTERS FOR MEDICARE	I AND HUMAN SERVICES			OMB NO. 093B-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI	ULTIPLE CONSTRUCTION LDING	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER WHOLISTIC 05			STREET ADDRESS: CITY, STATE ZIP COO 1500 FRANKLIN STREET, NE WASHINGTON, DC 20017	<u>.</u>
			PECADER'S PLAN OF COR	RECTION (X5)

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W 436	Continued From page 11 revealed that the client refused to wear them. Client #2's Individual Support Plan (ISP) dated 12/11/06 was reviewed on 8/21/07 at 1:36 PM. According the ISP, Client #2 wears eye glasses to compensate for her left eye impairment. There was no evidence that staff documented Client #2's refusal to wear her glasses. Additionally, there was no evidence of any program objective designed to train/teach Client #2 when to wear her eyeglesses.	W 438	in place to train person #2 to wear glasses
W 440		W 440	
	The finding includes: Interview with the Qualified Mental Retardation Professional (QMRP) and review of the staffing pattern on 8/20/07 at 3:50 PM revealed the scheduled shifts are as follows: Weekdays/Weekends		
	1st Shift 8 AM to 4 PM 2nd Shift 4 PM to 12 AM 3rd Shift 12 AM to 8 PM Further interview with the QMRP revealed that the		
	staff was required to conduct a drill once per month on each shift. Review of the fire drill log for August 2008 through October 2006 revealed that the facility failed to hold fire evacuation drills		

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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CENTERS FOR MEDICARS STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	& MEDICAID SERVICES (X1) PROVIDENSUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION A BUILDING	(X3) DAYE SURVEY COMPLETED
	D9G151	B. WING	09/22/2007

NAME OF PROVIDER OR SUPPLIER

WHOLISTIC 08

STREET ADDRESS, CITY, STATE, ZIP GODE 1600 FRANKLIN STREET, NE WASHINGTON, DC 20017

WHOLISTIC 08		י ו	(XB)		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)				
W 440	Continued From page 12 for the third shift. Further review of the fire drills logs for November 2006 through January 2007 revealed the facility falled to hold fire evacuation drills for the second shift. There was no evidence that fire drills were conducted quarterly on all shifts. 483.470(I)(1) EVACUATION DRILLS	W 440	Our quarterly achedule is based on a calendar year. HRA's may be based on survey year. Calendwill be adjusted to ensure quarterly variance in shift.	1 1	
	The facility must hold evacuation drills under varied conditions. This STANDARD is not met as evidenced by: Based on staff interview and record verification, the facility falled to hold evacuation drills under varied conditions.	·	Residents do not spend time in basement. We use that space fo storage primarily. However, it will be incorporated into fire drills prospectively.	T 7/44	
	The finding includes: Review of the facility's fire drill records on 8/20/07 at approximately 3:50 PM revealed that most of the fire drills were conducted via the front and back door exits. Review of the fire drill record revealed that the exit to besement had not been used at any time. Interview with the Qualified Mental Retardation Professional (QMRP) revealed that the facility had at least four method of egrees. Further interview with the QMRP revealed that the clients primarily used the front and back door exits during the past year. There was no evidence that evacuation drills were held under varied conditions.				

FORM CM8-2567(02-98) Previous Versions Obsoleta

Event ID: 2ME811

Fedility ID: 09G151

If continuation sheet Page 13 of 13

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION IDENTIFICATION NUMBER 151		UMBER:	A. SUILDII B. WING		(X3) DATE SU COMPLE QB/2		
NAME OF P	ROVIDER OR SUPPLIER TIC 08		1600 FRA	DRESS, CITY, NKLIN STR STON, DC 2	STATE, ZIP CCDE REET, NE 20017		_
(X4) ID PREFIX TAG	/ EACH DEPICIENC	atement of Deficienc y must be preceded b lbc identifying infori	Y FULL	PREFIX TAG	PRIVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X6) COMPLETE DATE
	20, 2007 through A was initiated using process. A randor were selected from with various disable. The findings of this chaevations at the program, interview day program, reviewed and investigation of the criminal history of contract worker for all jurisdictions employes or contract within the check. This Statute is not based on the revisited within the check. This Statute is not based on the revisited to ensure or the previous seven who have worked years prior to the The finding include Review of the per AM revealed the criminal background.	was conducted from August 22, 2007. The fundamental sum sample of two resumes a population of four littles. If the fundamental sum ample of two resumes as population of four littles. If the fundamental sum and additional check shall in the prospective emports. If the prospective emports a previous sever within which the prospective emports worker has work seven (7) years price the prospective sever (8) years price as evidenced ew of records, the Griminal background on (7) years, in all jur or resided within the check.	ton day home and ministrative if incident UIREMENT disclose the ployee or n (7) years, spective ked or or to the by: hecks for isdictions seven (7)	Ĭ	Six Staff multi Criminal backgo been initiated. take 4-6 weeks private investige	thocess shari	9/22

TATE FORM

2ME811

footinuation sheet 1 of

TATEMENT OF DEFICIENCIES IND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA (DENTIFICATION NUMBER:

PRINTED: 09/10/2007 FORM APPROVED

(X3) DATE SURVEY COMPLETED

	j			B. WING		08/2	<u>2/2007</u>
		09G151	STREET AD	DRESS, CITY, 8	TATE, ZIP CCDE		
OF PRO	OVIDER OR SUPPLIER		1600 FRA	NKLIN STRE	ET, NE		
OLISTI	C 08	•	WASHING	TON, DC 20)017 		1 2.2
i) (D EFIX AG		TEMENT OF DEFICIEN MUST BE PRECEDED SC IDENTIFYING INPO	BIFULL)D PREFIX TAG	PRIMOER'S PLAN OF (EACH CORRECTIVE ACT CROSS- LEFERENCED TO I DEFICIENCE	TON SHOULD BE THE APPROPRIATE	COMPLET DATE
1 000 1	NITIAL COMMEN	TS		1 000			
	A licensure survey 20, 2007 through A sample of two resi population of four t djaabilities.	ugust 22, 2007. 7 Idenis were select	ed from a		·		
,	The findings of this observations at the program, interview day program, review records to include and investigation r	e group nome, on a st both the grou w of clinical and a the facility's unus	e day p home end Idministrative				
	3503.8 BEDROOM			1 080			
	One (1) bathroom and a bathing facineeds of the residuse of each six (6) that non-live-in statellar person	ents shall be prov) persons including aff shall not be cou	lded for the g staff, excep Inted when				
-	This Statute is no Based on observing falled to have a to condition.	ation and interview	the GHMRP				9)-2
	The finding includes:				Talet has been F	ixed.	8/22
	8/21/07, the tollet was observed no House Manager r	nmental walk-thro located on the thi to flush. Interviet evenied that the t the residents earli	w with the pilet was				
1 082	3503.10 BEDRO	OMS AND BATHF	ROOMS	1 082			
th Regu	ilation Administration	3 Sharas	resentatives :	EIGNATIÍRE	Via Presid	dent 9/	(X8) DATE

(X2) MULTIPLE CONSTRUCTION

A BUILDING

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TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIES (X1) PROVIDER/SUPPLI		r/CLIA MBER:	(X2) MULTIPI A. BUILDING B. WING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED				
		0913151							
	VAME OF PROVIDER OR SUFFEREN			DRESS, CITY, STATE, ZIP CLOE LNKLIN STREET, NE STON, DC 20017					
(X4) ID PREFIX TAG	EFIX (EACH DEFICIENCY MUST BE FREGUNFORMATION)		rubb I	PREFIX TAG	PRIVIDER'S FLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	ISHOULD BE	(X8) GOMPLETE DATE		
I 082	equipped with tolle dispenser, spap for adequate lighting. This Statute is not Based on observaring the appropriate itemed. The findings included by the appropriate itemed. The findings included by the bathroom on the without a light of the four (4) times a year of the finding included interview with the professional (OM)	at is used by resident to tiesue, a paper town in hand washing, a mile tiesue, a paper town in hand washing, a mile tiens and interview at perly equip each bat me to meet each reside: If the paper town is a suidenced to the third level was obtained frectiveness of the place for each shift. If the tas avidenced the light is a suidenced to the place for each shift. If the tas avidenced the side execution drills of the place and record reside evacuation drills of the place are as follows:	y: the hroom with idents fire drills in an at least view, the juarterly on tardation e staffing	l 135	Light has cover.	ed	415		

Health Regulation Administration

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STATEMENT OF DEFICIENCIES	(X1) PROVIDER/BUPPLIER/CLIA IDENTIFICATION NUMBER:	(XZ) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
AND PLAN OF CORRECTION		A. BUILDING	1
	000154	8. WING	08/22/2007
	090151	THE COM STATE ZIE CODE	

NAME OF PROVIDER OR SUPPLIER

WHOLISTIC DA

STREET ADDRESS, CITY, STATE, ZIP CCIDE

1600 FRANKLIN STREET, NE WASHINGTON, DC 20017

WHOLIS1	ric 08	Washington, D		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY F REGULATORY OR LSC IDENTIFYING INFORMAT			COMPLETE DATE
I 135	Continued From page 2 1st Shift 8 AM to 4 PM 2nd Shift 12 AM to 12 AM 3rd Shift 12 AM to 8 PM Further interview with the QMRP revealed the staff was required to conduct a drill of month on each shift. Review of the fire of for August 2006 through October 2008 rethat the facility falled to hold fire evacuatifor the third shift. Further review of the fillegs for November 2006 through January revealed the facility failed to hold fire evadrills for the second shift. There was no that fire drills were conducted quarterly of shifts. Also see Federal Ddeficiency Citation W4	ince per drill log evested ion drills ire drills y 2007 scustion evidence on all	See W441	
1 202	Each staff person shall have a written jor description, which details each of his or responsibilities and duties and supervise control. This Statute is not met as evidenced by Based on record review, the GHMRP failed on file for review current job descriptions of the personnel files on 8/21/07 GHMRP failed to provide a job descriptionsulant #1.	ner major iled to letions for 7, the on for the	consultant jub description is incorporated in to consultant contract.	8/22/01
1 20	6 3509.6 PERSONNEL POLICIES	1 200	3	

Health Regulation Administration MAON STATE

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(X3) DATE SURVEY

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (UMBER:		R/CLIA MBER:	A BUILDING	LE CONSTRUCTION	(X3) DATE SU COMPLET	COMPLETED	
		09@151		8. WING _		08/22	/2007
NAME OF P	ROVIDER OR SUPPLIER		1600 FRAN	RESS, CITY, 8 IKLIN STRI TON, DC 20			
(X4) ID PREFIX TAG	"- A ALL ACEIGIENC	ATEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY LSC IDENTIFYING INFORM	PULL 1	ID PREFIX TAG	(EAC) CORRECT CROSS-REFERENCE	LAN OF CORRECTION TIVE ACTION SHOULD BE CED TO THE APPROPRIATE FICIENCY)	(X5) Complete Date
I 206	annually thereafter certification that a	age 3 flor to employment all shall provide a physical provide a physical health inventory has at the employee's he her to perform the re-	eith status i	206		·	
1 22	Based on Interview CHMRP failed to a health certificates The finding include Raview of person PM revealed no dehealth certificates	es: nel records on 8/21/0 ocumented evidence for consultant. [C1]	ine ad current 07 at 12:09	227	Current his in file,	ealth certificate	9/20
1 227	(c) infection control This Statute is no Based on record in have on file for re and CPR for emp The findings incluing the seconds revealed without current File	gram shall include, but owing: of for staff and reside of mat as evidenced to review, the GHMRP for view current training lipyees.	nts; alled to in first Aid ds/trainIng ff was		Staff has	current 7105 + Aid	9/22
Janika Bara	a. First Aid - C 1						1
Hesin Keg	CISADU VOU INISTRECT)			Alle	OME644	l/ continu	etion sheet 4 cf &

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN B. WING _	PLE CONSTRI	JETION	(X3) DATE & COMPL	ETED		
NAME OF B				DRESS, CITY, .	STATE, ZIP CC		00/2	2/2007
WHOLIS			1600 FRA	NKLIN STR TON, DC 2	EET, NE			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	(EACH	OVIDER'S PLAN OF CORRECTIVE ACTION SI REPERENCED TO THE AP DEFICIENCY)	らいしひ 日色	(X5) COMPLETE DATE
l 227	Continued From pe b. CPR - C 1 3521.1 HABILITAT	ige 4 ION AND TRAINING		1 420				
	training to its reside and maintain those more effectively with environments and the	i provide habilitation ents to enable them to life skills needed to the the demands of the achieve their optimand social functioning	o acquire cope sir num leveis		Caa	W249		
	Based on Interview GHMRP falled to p to its residents that and maintain life si environments and	met as evidenced by and record review, to revide habilitation and would enable them to cope where the cope was here optimum levide social functioning.	he d training to ecquire with their		260	ν ο μ · · ·		
	The finding include	·库:						
·	(Sée Federal Defic	iency Report Citation	s W249)				·	
,								